		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046219

Facility Name: Rivershores Nursing & Rehab Center, Llc

Address: 578 West Commercial Street (Number) Marseilles (City) 61341 (Zip Code)

County: Lasalle

Telephone Number: (815) 795-5121 **Fax #** (815) 795-4929

IDPA ID Number: 300124875001

Date of Initial License for Current Owners: 02/01/03

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	103	Skilled (SNF)	103	37,698	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	103	TOTALS	103	37,698	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	19,369	7,066	4,743	31,178	8
9	SNF/PED					9
10	ICF		31		31	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,369	7,097	4,743	31,209	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.79%

D. How many bed-hold days during this year were paid by Public Aid?
4 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/1/03

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/03 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 103 and days of care provided 4,429

Medicare Intermediary Riverbend Government Benefits Administrator

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	157,212	20,616	7,160	184,988		184,988	2,079	187,067			1
2	Food Purchase		136,534		136,534		136,534	(2,442)	134,092			2
3	Housekeeping	64,298	14,086		78,384		78,384	(1,545)	76,839			3
4	Laundry	45,703	11,664		57,367		57,367	(133)	57,234			4
5	Heat and Other Utilities			104,829	104,829		104,829	780	105,609			5
6	Maintenance	59,730		57,141	116,871		116,871	(825)	116,046			6
7	Other (specify):*							724	724			7
8	**TOTAL General Services**	326,943	182,900	169,130	678,973		678,973	(1,362)	677,611			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,615,137	69,609	158,104	1,842,850		1,842,850	2,820	1,845,670			10
10a	Therapy	34,895		375	35,270		35,270		35,270			10a
11	Activities	76,547	15,280	789	92,616		92,616		92,616			11
12	Social Services	82,076		1,124	83,200		83,200	5,610	88,810			12
13	Nurse Aide Training											13
14	Program Transportation			557	557		557		557			14
15	Other (specify):*							2,371	2,371			15
16	**TOTAL Health Care and Programs**	1,808,655	84,889	169,949	2,063,493		2,063,493	10,801	2,074,294			16
	C. General Administration											
17	Administrative	76,826			76,826		76,826	7,093	83,919			17
18	Directors Fees											18
19	Professional Services			133,221	133,221		133,221	(92,921)	40,300			19
20	Dues, Fees, Subscriptions & Promotions			37,141	37,141		37,141	(17,917)	19,224			20
21	Clerical & General Office Expenses	88,056	10,835	76,540	175,431		175,431	39,120	214,551			21
22	Employee Benefits & Payroll Taxes			393,903	393,903		393,903	(2,201)	391,702			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,624	2,624		2,624	2,074	4,698			24
25	Other Admin. Staff Transportation			8,777	8,777		8,777		8,777			25
26	Insurance-Prop.Liab.Malpractice			101,264	101,264		101,264	425	101,689			26
27	Other (specify):*							11,930	11,930			27
28	**TOTAL General Administration**	164,882	10,835	753,470	929,187		929,187	(52,397)	876,790			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,300,480	278,624	1,092,549	3,671,653		3,671,653	(42,958)	3,628,695			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc #0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			17,543	17,543		17,543	52,679	70,222			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			55,397	55,397		55,397	72,504	127,901			32
33	Real Estate Taxes			34,079	34,079		34,079	964	35,043			33
34	Rent-Facility & Grounds			300,760	300,760		300,760	(298,311)	2,449			34
35	Rent-Equipment & Vehicles			3,239	3,239		3,239	935	4,174			35
36	Other (specify):*											36
37	**TOTAL Ownership**			411,018	411,018		411,018	(171,229)	239,789			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		300,297	225,625	525,922		525,922	(22,067)	503,855			39
40	Barber and Beauty Shops			9,663	9,663		9,663	(9,663)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,548	56,548		56,548		56,548			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		300,297	291,836	592,133		592,133	(31,730)	560,403			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,300,480	578,921	1,795,403	4,674,804		4,674,804	(245,918)	4,428,886			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,200)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(45,489)	30		9
10	Interest and Other Investment Income	(22)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(310)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(37,200)	21		24
25	Fund Raising, Advertising and Promotional	(16,981)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(927)	20		28
29	Other-Attach Schedule	(33,418)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (136,548)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(109,370)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (109,370)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (245,918)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Rivershores Nursing & Rehab Center, Llc

IDF 0046219

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Building Company - Bank Charges	$ (354)	21	1
2	Building Company - Filing Fees	(250)	21	2
3	Cable	(658)	6	3
4	Capitalized R&M	(1,783)	6	4
5	Rental Income	(1,948)	6	5
6	Other Income	(219)	21	6
7	Patient Clothing	(64)	10	7
8	Barber & Beauty	(9,663)	40	8
9	Amortization	(17,017)	31	9
10	PPA - License Expense	(1,462)	20	10
11				11
12				12
13				13
14				14
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94				94
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96				96
97				97
98				98
99				99
100				100
101	Total	(33,418)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary					205		1,862	12				2,079	1
2	Food Purchase	(2,510)							68				(2,442)	2
3	Housekeeping				(1,545)								(1,545)	3
4	Laundry				(133)								(133)	4
5	Heat and Other Utilities					780							780	5
6	Maintenance	(4,389)			(48)	833		2,778	1				(825)	6
7	Other (specify):*						28	679	17				724	7
8	**TOTAL General Services**	(6,899)			(1,725)	1,818	28	5,319	98				(1,362)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(64)			(6,826)			9,710					2,820	10
10a	Therapy													10a
11	Activities													11
12	Social Services							5,610					5,610	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*						130	2,241					2,371	15
16	**TOTAL Health Care and Programs**	(64)			(6,826)		130	17,561					10,801	16
	C. General Administration													
17	Administrative							7,085	8				7,093	17
18	Directors Fees													18
19	Professional Services					(92,922)			1				(92,921)	19
20	Fees, Subscriptions & Promotions	(19,370)				1,453							(17,917)	20
21	Clerical & General Office Expenses	(38,023)	604			7,608		68,916	15				39,120	21
22	Employee Benefits & Payroll Taxes			(949)	(164)		(1,088)						(2,201)	22
23	Inservice Training & Education													23
24	Travel and Seminar					2,070			4				2,074	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice					422			3				425	26
27	Other (specify):*						903	11,027					11,930	27
28	**TOTAL General Administration**	(57,393)	604	(949)	(164)	(81,369)	(185)	87,028	31				(52,397)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(64,356)	604	(949)	(8,716)	(79,551)	(27)	109,908	129				(42,958)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(45,489)	82,870			7,734				7,564			52,679	30
31	Amortization of Pre-Op. & Org.	(17,017)	17,017											31
32	Interest	(22)	71,681							845			72,504	32
33	Real Estate Taxes					964							964	33
34	Rent-Facility & Grounds		(300,760)			2,432			17				(298,311)	34
35	Rent-Equipment & Vehicles					935							935	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(62,528)	(129,192)			12,065			17	8,409			(171,229)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(6,124)				(293)	(15,650)			(22,067)	39
40	Barber and Beauty Shops	(9,663)											(9,663)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(9,663)			(6,124)				(293)	(15,650)			(31,730)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(136,548)	(128,588)	(949)	(14,840)	(67,486)	(27)	109,908	(147)	(7,241)			(245,918)	45

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Rivershores Property LLC		Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 300,760	Rivershores Property LLC		$	$ (300,760)	1
2	V	21	Bank Service Charge				354	354	2
3	V	21	Filing Fees				250	250	3
4	V	30	Depreciation				82,870	82,870	4
5	V	31	Amortization				17,017	17,017	5
6	V	32	Interest				71,681	71,681	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 300,760			$ 172,172	$ * (128,588)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 174,733	$ 174,733	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	175,682	CCS EMPLOYEE BENEFIT GROUP	100.00%		(175,682)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 175,682			$ 174,733	$ * (949)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$	XCEL MEDICAL SUPPLY, LLC	100.00%	$	$	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	10,412	XCEL MEDICAL SUPPLY, LLC	100.00%	8,868	(1,545)	17
18	V	04	LAUNDRY	893	XCEL MEDICAL SUPPLY, LLC	100.00%	761	(133)	18
19	V	06	REPAIRS & MAINTENANCE	323	XCEL MEDICAL SUPPLY, LLC	100.00%	275	(48)	19
20	V	10	NURSING	46,010	XCEL MEDICAL SUPPLY, LLC	100.00%	39,184	(6,826)	20
21	V	10A	THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS	1,107	XCEL MEDICAL SUPPLY, LLC	100.00%	943	(164)	24
25	V	39	ANCILLARY	41,281	XCEL MEDICAL SUPPLY, LLC	100.00%	35,156	(6,124)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 100,027			$ 85,187	$ * (14,840)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 205	$ 205	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	780	780	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	833	833	17
18	V	10	Nursing		Care Centers, Inc.	100.00%			18
19	V	11	Activities		Care Centers, Inc.	100.00%			19
20	V	19	Professional Fees	97,122	Care Centers, Inc.	100.00%	4,200	(92,922)	20
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	1,453	1,453	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	7,608	7,608	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	2,070	2,070	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	422	422	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	7,734	7,734	25
26	V	32	Interest		Care Centers, Inc.	100.00%			26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	964	964	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	2,432	2,432	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	935	935	29
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			30
31	V	02	Food		Care Centers, Inc.	100.00%			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 97,122			$ 29,636	$ * (67,486)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$ 194	Care Centers, Inc.	100.00%	$ 194	$	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	28	28	16
17	V	10	Nursing Salary	517	Care Centers, Inc.	100.00%	517		17
18	V	10a	Rehab Salary	375	Care Centers, Inc.	100.00%	375		18
19	V	11	Activity Salary		Care Centers, Inc.	100.00%			19
20	V	12	Social Service Salary		Care Centers, Inc.	100.00%			20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	130	130	21
22	V	17	Administration Salary		Care Centers, Inc.	100.00%			22
23	V	21	Office Salary	6,170	Care Centers, Inc.	100.00%	6,170		23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	903	903	24
25	V	22	Employee Benefits	1,088	Care Centers, Inc.	100.00%		(1,088)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,344			$ 8,317	$ * (27)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$	Care Centers, Inc.	100.00%	$ 1,862	$ 1,862	15
16	V	03	Housekeeping Salary		Care Centers, Inc.	100.00%			16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	2,778	2,778	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	679	679	18
19	V	10	Nursing Salary		Care Centers, Inc.	100.00%	9,710	9,710	19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			20
21	V	12	Social Services Salary		Care Centers, Inc.	100.00%	5,610	5,610	21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	2,241	2,241	22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	7,085	7,085	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	68,916	68,916	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	11,027	11,027	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 109,908	$ * 109,908	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 134	Care Centers, Inc. - Health Systems Division	100.00%	$ 32	$ (102)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	68	68	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	1	1	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	8	8	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	1	1	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%			20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	15	15	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	4	4	22
23	V	26	Insurance		Care Centers, Inc. - Health Systems Division	100.00%	3	3	23
24	V	32	Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%			24
25	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	17	17	25
26	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%			26
27	V	39	Ancillary Enteral Supplies	594	Care Centers, Inc. - Health Systems Division	100.00%	301	(293)	27
28	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	114	114	28
29	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	17	17	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 728			$ 581	$ * (147)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Vent Lease, LLC.	100.00%	$ 7,564	$ 7,564	15
16	V	32	Interest		Vent Lease, LLC.	100.00%	845	845	16
17	V	39	Vent Reimbursement	15,650	Vent Lease, LLC.	100.00%		(15,650)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 15,650			$ 8,409	$ * (7,241)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrator	1.00%	See Attached	0.66	1.43%		$		1
2	Adam Vales	Owner	Clerical	11.00%	See Attached	1.14	2.85%	Alloc Salary	1,178	22-7	2
3	Mark Steinberg	Relative	Administrator		See Attached	0.95	1.73%	Alloc Salary	1,271	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 2,449		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 2201 WEST MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURA	DIRECT ALLOCATION			$	$		$ 174,733	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 174,733	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						8,868	3
4	04	LAUNDRY	Direct Allocation						761	4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						275	5
6	10	NURSING	Direct Allocation						39,184	6
7	10A	THERAPY	Direct Allocation							7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation						943	10
11	39	ANCILLARY	Direct Allocation						35,156	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 85,187	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,484,397	42	$ 9,730	$	31,209	$ 205	1
2	05	Utilities	Patient Days	1,484,397	42	37,103		31,209	780	2
3	06	Maintenance	Patient Days	1,484,397	42	39,622		31,209	833	3
4	10	Nursing	Patient Days	1,484,397	42			31,209		4
5	11	Activities	Patient Days	1,484,397	42			31,209		5
6	19	Professional Fees	Patient Days	1,484,397	42	199,755		31,209	4,200	6
7	20	Dues and Subscriptions	Patient Days	1,484,397	42	69,116		31,209	1,453	7
8	21	Office & Clerical	Patient Days	1,484,397	42	361,868		31,209	7,608	8
9	24	Travel and Seminar	Patient Days	1,484,397	42	98,454		31,209	2,070	9
10	26	Insurance	Patient Days	1,484,397	42	20,081		31,209	422	10
11	30	Depreciation	Patient Days	1,484,397	42	367,842		31,209	7,734	11
12	32	Interest	Patient Days	1,484,397	42			31,209		12
13	33	Real Estate Taxes	Patient Days	1,484,397	42	45,838		31,209	964	13
14	34	Rent - Building	Patient Days	1,484,397	42	115,677		31,209	2,432	14
15	35	Rent - Equipment & Auto	Patient Days	1,484,397	42	44,486		31,209	935	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,409,572	$		$ 29,636	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			264,919	264,919		194	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			38,757			28	2
3	10	Nursing Salary	Direct Cost			209,584	209,584		517	3
4	10a	Rehab Salary	Direct Cost			66,982	66,982		375	4
5	11	Activity Salary	Direct Cost							5
6	12	Social Service Salary	Direct Cost			66,710	66,710			6
7	15	Emp. Ben. - Healthcare	Direct Cost			50,220			130	7
8	17	Administration Salary	Direct Cost			38,431	38,431			8
9	21	Office Salary	Direct Cost			525,935	525,935		6,170	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			82,566			903	10
11	22	Employee Benefits								11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,344,103	$ 1,172,560		$ 8,317	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,484,397	42	88,579	88,579	31,209	1,862	1
2	03	Housekeeping Salary	Patient Days	1,484,397	42			31,209		2
3	06	Maintenance Salary	Patient Days	1,484,397	42	132,146	132,146	31,209	2,778	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,484,397	42	32,292		31,209	679	4
5	10	Nursing Salary	Patient Days	1,484,397	42	461,827	461,827	31,209	9,710	5
6	10a	Rehab Salary	Patient Days	1,484,397	42			31,209		6
7	12	Social Services Salary	Patient Days	1,484,397	42	266,840	266,840	31,209	5,610	7
8	15	Emp. Ben. - Healthcare	Patient Days	1,484,397	42	106,602		31,209	2,241	8
9	17	Administration Salary	Patient Days	1,484,397	42	336,976	336,976	31,209	7,085	9
10	21	Office Salary	Patient Days	1,484,397	42	3,277,864	3,277,864	31,209	68,916	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,484,397	42	524,485		31,209	11,027	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,227,610	$ 4,564,232		$ 109,908	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,144,835		93,149		729	$ 32	1
2	02	Food	Billable Income	2,144,835		987,169		729	335	2
3	06	Maintenance	Billable Income	2,144,835		3,597		729	1	3
4	17	Administration	Billable Income	2,144,835		24,000		729	8	4
5	19	Professional Fees	Billable Income	2,144,835		2,500		729	1	5
6	20	Dues & Subscriptions	Billable Income	2,144,835		1,342		729		6
7	21	Office & Clerical	Billable Income	2,144,835		43,384		729	15	7
8	24	Travel & Seminar	Billable Income	2,144,835		10,755		729	4	8
9	26	Insurance	Billable Income	2,144,835		9,262		729	3	9
10	32	Interest Expense	Billable Income	2,144,835		1,371		729		10
11	34	Rent - Building	Billable Income	2,144,835		50,000		729	17	11
12	35	Rent - Equipment & Auto	Billable Income	2,144,835		1,080		729		12
13	39	Ancillary Enteral Supplies	Billable Income	2,144,835		98,519		729	33	13
14	01	Dietary - Salary	Billable Income	2,144,835		335,801	335,801	729	114	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	2,144,835		49,127		729	17	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,711,055	$ 335,801		$ 580	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Direct Billing	620,670	29	$ 300,000	$	15,650	$ 7,564	1
2	32	Interest	Direct Billing	620,670	29	33,493		15,650	845	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 333,493	$		$ 8,409	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LaSalle Bank		X	Mortgage			$	$ 1,167,377			$ 71,681	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	LaSalle Bank		X	Line of Credit				1,525,008			55,397	6
7	Genesis (prior owner)							1,602				7
8	See Supplemental Schedule										845	8
9	TOTAL Facility Related						$	$ 2,693,987			$ 127,923	9
	B. Non-Facility Related*											
10	Interest Income										(22)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (22)	14
15	TOTALS (line 9+line14)						$	$ 2,693,987			$ 127,901	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocated from Vent Lease						$	$			$ 845	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										845	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc **#** 0046219 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	33,966	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	34,156	2
3. Under or (over) accrual (line 2 minus line 1).	$	190	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	34,852	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	35,042	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	34,169	8
	2000	34,274	9
	2001	34,680	10
	2002	32,348	11
	2003	33,192	12

2004 Accrual = 2003 Tax $33,192 x 1.05 = $34,852

Care Center allocation $964

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rivershores Nursing & Rehab Center, Llc COUNTY Lasalle

FACILITY IDPH LICENSE NUMBER 0046219

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-49-325-008	Long Term Care Property	$ 33,192.48	$ 33,192.48
2.	See Attached	Allocated from Home Office	$ 106,873.39	$ 964.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 140,065.87	$ 34,156.48

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rivershores Nursing & Rehab Center, Llc COUNTY Lasalle

FACILITY IDPH LICENSE NUMBER 0046219

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,830 B. General Construction Type: Exterior Brick Frame Masonry Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	139,498	2003	$ 155,704	1
2	2201 Main LLC			7,394	2
3	TOTALS	139,498		$ 163,098	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		1,401,342	31,075		35,034	3,959	66,164	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		28,528	1,172		1,172		2,433	68
69	Financial Statement Depreciation			12,246			(12,246)		69
70	TOTAL (lines 4 thru 69)		$ 1,429,870	$ 44,493		$ 36,206	$ (8,287)	$ 68,597	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,429,870	$ 44,493		$ 36,206	$ (8,287)	$ 68,597	1
2	Fire Alarm Control Panel	2003	692		20	35	35	66	2
3	Generator Repairs	2003	740		20	37	37	65	3
4	Vinyl Sheets For Showers	2003	542		20	108	108	136	4
5	Gutters	2003	10,300		20	515	515	644	5
6	Repair Roof Valleys	2003	900		20	45	45	56	6
7	A O Smith Water Heater	2003	3,036		20	152	152	177	7
8	Extra Re: Gutters	2003	976		20	49	49	57	8
9	Dig Up Floor For Rooter	2003	879		20	44	44	51	9
10	3 Ton Air Compressor	2003	1,388		20	278	278	393	10
11	Roof Repairs	2004	7,800		20	228	228	228	11
12	Two Nursing Stations	2004	15,660		20	457	457	457	12
13	Indoor Decorating	2004	1,190		20	30	30	30	13
14	Install Attic Exhaust Fans	2004	2,014		20	42	42	42	14
15	Painting	2004	77,875		20	2,271	2,271	2,271	15
16	New Floors	2004	57,398		20	2,214	2,214	2,214	16
17	Seal, Stripe & Repair Parking Lot ***	2004	7,000		20	204	204	204	17
18	15Kw Booster Heater	2004	972		20	16	16	16	18
19	Nurse Station Gates	2004	700		20	9	9	9	19
20	Plumbing - Foot Control	2004	514		20	26	26	26	20
21	Generator Repairs	2004	1,268		20	42	42	42	21
22	*** $1500 Credit Received After Capital Report Filed	2004			20				22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,621,714	$ 44,493		$ 43,008	$ (1,485)	$ 75,781	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,621,714	$ 44,493		$ 43,008	$ (1,485)	$ 75,781	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,621,714	$ 44,493		$ 43,008	$ (1,485)	$ 75,781	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,621,714	$ 44,493		$ 43,008	$ (1,485)	$ 75,781	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,621,714	$ 44,493		$ 43,008	$ (1,485)	$ 75,781	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 1,621,714	$ 44,493		$ 43,008	$ (1,485)	$ 75,781	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,621,714	$ 44,493		$ 43,008	$ (1,485)	$ 75,781	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 1,621,714	$ 44,493		$ 43,008	$ (1,485)	$ 75,781	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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19									19
20									20
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,621,714	$ 44,493		$ 43,008	$ (1,485)	$ 75,781	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 1,621,714	$ 44,493		$ 43,008	$ (1,485)	$ 75,781	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,621,714	$ 44,493		$ 43,008	$ (1,485)	$ 75,781	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 1,621,714	$ 44,493		$ 43,008	$ (1,485)	$ 75,781	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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18									18
19									19
20									20
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,621,714	$ 44,493		$ 43,008	$ (1,485)	$ 75,781	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 1,621,714	$ 44,493		$ 43,008	$ (1,485)	$ 75,781	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,621,714	$ 44,493		$ 43,008	$ (1,485)	$ 75,781	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 1,621,714	$ 44,493		$ 43,008	$ (1,485)	$ 75,781	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,621,714	$ 44,493		$ 43,008	$ (1,485)	$ 75,781	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 1,621,714	$ 44,493		$ 43,008	$ (1,485)	$ 75,781	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,621,714	$ 44,493		$ 43,008	$ (1,485)	$ 75,781	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	103		2003		$ 1,401,342	$ 31,075	40	$ 35,034	$ 3,959	$ 66,164	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,401,342	$ 31,075		$ 35,034	$ 3,959	$ 66,164	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main LLC			2002	$ 10,190	$ 255	40	$ 255	$	$ 637	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - 2201 Main LLC			2002	8,418	421	20	421		1,052	9
10	Allocation - 2201 Main LLC			2003	9,920	496	20	496		744	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 28,528	$ 1,172		$ 1,172	$	$ 2,433	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 200,507	$ 63,707	$ 19,703	$ (44,004)	10	$ 59,460	71
72	Current Year Purchases	36,766	6,434	6,434		10	6,434	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 237,273	$ 70,141	$ 26,137	$ (44,004)		$ 65,894	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Care Centers Allocation		$ 14,580	$ 1,077	$ 1,077	$	5	$ 12,126	76
77										77
78										78
79										79
80	TOTALS			$ 14,580	$ 1,077	$ 1,077	$		$ 12,126	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,036,665	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 115,711	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 70,222	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (45,489)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 153,801	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocated from Care Centers				2,449			5
6								6
7	TOTAL				$ 2,449 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 4,173 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 30,569	$		$ 30,569	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			8,689			8,689	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			186,367			186,367	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				209,964		209,964	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						90,333		90,333	13
14	TOTAL			$		$ 225,625	$ 300,297		$ 525,922	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 25,827	$ 49,715	1
2	Cash-Patient Deposits	15,058	15,058	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,005,459	1,005,459	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,066	12,066	6
7	Other Prepaid Expenses	3,000	3,000	7
8	Accounts Receivable (owners or related parties)	152,732	146,854	8
9	Other(specify): See Attached Schedule	17,425	72,018	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,231,567	$ 1,304,170	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		155,704	13
14	Buildings, at Historical Cost		1,614,615	14
15	Leasehold Improvements, at Historical Cost	202,164	202,164	15
16	Equipment, at Historical Cost	28,314	186,871	16
17	Accumulated Depreciation (book methods)	(18,740)	(177,229)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	7,318	27,949	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 219,056	$ 2,010,074	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,450,623	$ 3,314,244	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 384,588	$ 384,588	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,758	14,758	28
29	Short-Term Notes Payable	1,525,008	1,526,610	29
30	Accrued Salaries Payable	158,745	158,745	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,083	9,083	31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,852	34,852	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	130,723	134,285	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,257,757	$ 2,262,921	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,167,377	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 1,167,377	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,257,757	$ 3,430,298	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (807,134)	$ (116,054)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,450,623	$ 3,314,244	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (318,758)	1	
2	Restatements (describe):		2	
3	See Attached	(12,019)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (330,777)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(476,357)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (476,357)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (807,134)	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,037,276	1
2	Discounts and Allowances for all Levels	(1,107,381)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,929,895	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	916,389	6
7	Oxygen	4,498	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 920,887	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	12,242	13
14	Non-Patient Meals	2,200	14
15	Telephone, Television and Radio	658	15
16	Rental of Facility Space	1,948	16
17	Sale of Drugs	197,015	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	41,286	19
20	Radiology and X-Ray		20
21	Other Medical Services	87,291	21
22	Laundry	3,543	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 346,183	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	22	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 22	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,460	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,460	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,198,447	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	678,973	31
32	Health Care	2,063,493	32
33	General Administration	929,187	33
	B. Capital Expense		
34	Ownership	411,018	34
	C. Ancillary Expense		
35	Special Cost Centers	535,585	35
36	Provider Participation Fee	56,548	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,674,804	40
41	**Income before Income Taxes (line 30 minus line 40)****	(476,357)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (476,357)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** not complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,637	1,981	$ 62,312	$ 31.45	1
2	Assistant Director of Nursing	1,941	2,451	59,180	24.15	2
3	Registered Nurses	17,038	19,419	457,477	23.56	3
4	Licensed Practical Nurses	9,031	10,163	211,330	20.79	4
5	Nurse Aides & Orderlies	60,314	67,830	789,115	11.63	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,505	3,035	34,895	11.50	8
9	Activity Director	1,887	2,109	34,641	16.43	9
10	Activity Assistants	4,595	5,070	41,906	8.27	10
11	Social Service Workers	5,072	5,489	82,076	14.95	11
12	Dietician					12
13	Food Service Supervisor	1,919	2,191	38,980	17.79	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,004	15,383	118,232	7.69	15
16	Dishwashers					16
17	Maintenance Workers	3,836	4,274	59,730	13.98	17
18	Housekeepers	7,201	8,145	64,298	7.89	18
19	Laundry	5,711	6,239	45,703	7.33	19
20	Administrator	1,987	2,174	76,826	35.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,208	5,765	88,056	15.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,908	2,176	35,723	16.42	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	145,794	163,894	$ 2,300,480 *	$ 14.04	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	159	$ 7,160	01-03	35
36	Medical Director	monthly	9,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	3,399	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	789	11-03	44
45	Social Service Consultant	17	1,124	12-03	45
46	Other(specify)				46
47	Dental Consultant		1,443	10-03	47
48	CCI - see attached		892	10-03	48
49	TOTAL (lines 35 - 48)	192	$ 23,807		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,669	$ 69,809	10-03	50
51	Licensed Practical Nurses	2,191	82,487	10-03	51
52	Nurse Aides	20	449	10-03	52
53	TOTAL (lines 50 - 52)	3,880	$ 152,745		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra Leonard	Administrator	0	$ 41,289
Richard Bateman	Administrator	0	35,537
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,826

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Care Centers Inc.	Home Office Expense	$ 74,160
Care Centers Inc.	Bookkeeping Services	21,012
National Datacare	Data Processing	1,520
Frost Ruttenberg & Rothblatt	Accounting	15,429
Various - see attached	Legal	5,489
TBT Enterprises	Unemployment Consultant	777
Care Centers Inc.	Professional Fees	1,950
ADP	Payroll	8,064
Keane Care	Data Processing	3,418
Achieve Healthcare	Data Processing	1,400
Site Builder	Data Processing	2
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 133,221

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 89,814
Unemployment Compensation Insurance	51,960
FICA Taxes	164,642
Employee Health Insurance	80,126
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Welfare	3,128
Holiday Expense	1,998
Drug Testing	34
TOTAL (agree to Schedule V, line 22, col.8)	$ 391,702

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,702
Health Care Worker Background Check	
(Indicate # of checks performed 56)	924
Dues & Subscriptions	4,064
Licenses & Fees	2,081
Advertising & Promotion	16,981
Yellow Page Advertising	927
Allocated from Care Centers	1,453
Less: Public Relations Expense	( )
Non-allowable advertising	(16,981)
Yellow page advertising	(927)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,224

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,227
Educational Expense	397
Allocated from Care Centers	2,074
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,698

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc # 0046219 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rivershores Nursing & Rehab Center, Llc **#** 0046219 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,692** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **56,548**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,200**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.